

OR BOOKING FORM

Please Fax Completed Form to: (732) 680-8883/ (732)499-7568

Procedure Date: _____ Time _____ AM/PM/TF (To Follow)

Primary Surgeon: _____ Primary Physician: _____

Pt's Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ SS#: _____ Gender: _____

Home #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy: _____ Location: _____ Phone: _____

Admitting DX & ICD Codes: _____

Procedures & CPT Codes: _____

(Please include FULL description of Procedures and CPT/ICD Codes)

Instrumentation/Implant/Graft/Tissue Needed: ____ Yes/____ No C-Arm _____

1st Company: _____ Rep.: _____ Phone #: _____

2nd Company: _____ Rep.: _____ Phone #: _____

Physical Therapy (Crutch /Walker Training): ____ Yes ____ No (if YES please send orders attached)

PRIMARY INSURANCE: PLEASE FILL OUT OR FORWARD COPIES OF BOTH SIDES OF INSURANCE CARDS

Insurance Co: _____ Phone #: _____

Policy#/Claim#: _____ Group#: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber DOB: _____ Age: _____ Subscriber Contact #: _____

SECONDARY INSURANCE:

Insurance Co: _____ Phone #: _____

Policy#/Claim#: _____ Group#: _____

Subscriber: _____ Relationship to Patient: _____

Subscriber DOB: _____ Age: _____ Subscriber Contact #: _____

Pre-Cert #: _____ Pre-Cert Date: _____ No Pre-Cert Req: _____

Patient Status Order:

(Please check only one)

SDS (anticipate discharge on same calendar day) _____

SDS with Extended Recovery (anticipate overnight stay) _____

Minor Surgery _____

Admit to Inpatient _____

P.A.T. Date: _____ Time: _____ AM/PM Booked w/ _____

Surgeon Signature: _____ Date: _____ Time: _____ AM/PM

PLEASE CALL (732)499-6145/6017 TO CANCEL or RE-SCHEDULE PROCEDURES

Revised 10/11/17 pdy